Department of Health and Human Services
Vocational Rehabilitation Program
REFERRAL DATA SHEET

*Form completed by: Date:

First Name, Middle, Last Name:

Current Address: Zip:

Telephone No: County:

Age: Current or Last School Attended:

Social Security # : DOB:

Do you have a guardian? Yes ☐ No ☐ Guardian's Name:

PREVIOUS CLIENT? Yes ☐ No ☐

What is your disability? How does it limit you?

I am interested in services to help me with:
_____Maintaining a job
_____ Preparing for a job
_____Finding a job

Are you currently in treatment? Yes☐ No ☐(if yes) Where?

Do you receive: SSI SSDI Food Stamps Medicare Medicaid ACTT

Referral Source:

(Agency)	(Contact Person)	(Phone #)
Charlotte Mecklenburg Schools	Tracy Hales	980-343-5328

(Other) (Self)

FOR OFFICE USE ONLY

Appointment scheduled by email/mail _____ phone _____ in person _____ or applicant packet _____
Mail distributed _____
(Date)